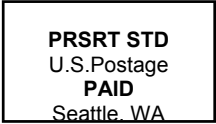




Communicable Disease and Epidemiology News

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- **Preparing for SARS: Steps to Take Now in the Absence of SARS Activity Worldwide**
- **Risk of Transmission of Hepatitis B and C in the Outpatient Setting**

Preparing for SARS: Steps to Take Now in the Absence of SARS Activity Worldwide

The United States virtually escaped last year's SARS worldwide epidemic of 8,437 cases and 813 deaths, with only 8 confirmed cases. However, the Centers for Disease Control (CDC) and the World Health Organization (WHO) believe it is only a matter of time until SARS resurfaces, and there is no guarantee that the US will be spared the next time around. Therefore, it is essential to prepare for the potential re-emergence of SARS. **CDC has posted draft guidelines for SARS preparedness planning on their website. Clinicians and hospital planners should review the section on SARS preparedness guidelines for health care facilities which contain guidance for both inpatient and outpatient settings.** A critical component of SARS preparedness planning is surveillance, which includes the early identification, reporting, and tracking of cases with prompt identification, evaluation and monitoring of close contacts of cases.

This year, SARS screening criteria and infection control recommendations in health care settings will be linked to the level of SARS activity worldwide, and locally. As the SARS situation changes, screening and disease control recommendations will change accordingly.

In the absence of recognized SARS coronavirus (Co-V) activity worldwide (our current situation), health care providers and hospitals are on the front lines in terms of identifying potential first, or "sentinel" cases of SARS. Because the clinical presentation of SARS is nonspecific and there is no rapid diagnostic test, **SARS screening guidelines for clinicians emphasize epidemiological criteria to identify exposures to SARS Co-V among persons with a compatible clinical syndrome.**

To increase the specificity (the likelihood that someone meeting the screening criteria actually has SARS) of SARS surveillance, in the absence of SARS activity worldwide, **screening for SARS at this time is focused only on**

hospitalized patients with chest x-ray (CXR) diagnosed pneumonia. Screening questions are targeted to identify patients who may be at increased risk for SARS based on epidemiological criteria. These groups include recent travelers to previously SARS-affected countries (and their close contacts), health care workers, and persons who are part of a cluster of pneumonia cases. Taking a thorough travel and social history will be important.

The following three screening questions should be asked of all hospitalized patients with CXR-confirmed pneumonia:

- 1) **"Do you have a history of recent travel (within 10 days of symptom onset) to a previously SARS-affected area, or close contact with ill persons with a history of travel to such areas?"**
- 2) **"Are you employed as a health care worker with direct patient contact?"**
- 3) **"Do you have close contacts who have pneumonia?"**

If a hospitalized patient with CXR-confirmed pneumonia answers "yes" to any of these three questions, the following actions will need to be taken:

- ✓ **Institute droplet precautions.**
- ✓ **Notify hospital infection control.**
- ✓ **Notify Public Health immediately at (206) 296-4774, day or night.**
- ✓ **Consider SARS testing (in consultation with Public Health) if no alternative diagnosis is found within 72 hours.**

Although current SARS-CoV serological tests are sensitive and specific, when disease prevalence is low, the positive predictive value of the tests is low, leading to high false positive rate. Therefore, SARS-CoV testing needs to be used judiciously, and should be limited to patients with epidemiological risk factors and clinical syndromes consistent with SARS.

When notifying Public Health of hospitalized, CXR-confirmed pneumonia cases, who answered "yes" to one of the three screening questions, please provide demographic information (name, address, phone, DOB), clinical information, and SARS risk factor information.

What is "Respiratory Etiquette"?

"Respiratory etiquette" is a set of strategies proposed by CDC for use in healthcare settings to reduce the transmission of all respiratory pathogens (including SARS). It includes any or all of the following:

- Providing surgical masks or tissues to all patients presenting with respiratory symptoms
- Segregating patients with respiratory symptoms from other patients and putting them in a private room or cubicle as soon as possible
- Use of surgical masks by healthcare workers when evaluating patients with respiratory symptoms
- Providing hand hygiene materials in waiting areas and encouraging patients with respiratory symptoms to use them
- Considering the use of plexiglass barriers to protect registration and triage staff from unmasked patients

Next month’s *EPI-LOG*, will contain additional information about SARS. The CDC is frequently updating their website with SARS information for health care providers, hospitals, and the public. You can find it all at: <http://www.cdc.gov/ncidod/sars/>

Transmission of Hepatitis B and C in Outpatient Settings Associated with Unsafe Injection Practices

An article in the September 26, 2003 issue of the Morbidity and Mortality Weekly Report (MMWR) described four investigations into the suspected transmission of hepatitis B virus (HBV) and hepatitis C virus (HCV) in outpatient settings in New York, Oklahoma, and Nebraska. The following is a summary of that article:

Seven patients who had undergone endoscopic procedures at a private physicians office in New York City (NYC) developed acute HCV infection. In May, 2002, an epidemiologic investigation identified 5 additional clinic-acquired acute HCV infections; all 12 patients had had a procedure performed within 3 days after a patient with chronic HCV infection. The HCV genotype from six of the acutely infected patients, and the patient with chronic infection were all type 2c, which is rare in the US. The likely transmission route was contamination of multiple-dose anesthesia medication vials.

In December 2001, 1042 patients at a NYC clinic were offered HBV and HCV testing, after two elderly patients of that clinic were diagnosed with acute HBV. Thirty-eight additional patients with acute HBV infection were identified. A retrospective cohort study showed that receipt of injections at the clinic was associated with becoming infected with HBV.

A pain remediation clinic in Oklahoma was investigated in August 2002 after 6 patients of the clinic developed suspected acute HBV infection. There were 69 HCV and 31 HBV infections identified among the 793 patients who were tested. The investigation found that a Certified Registered Nurse Anesthetist had reused needles and syringes routinely during clinic sessions, treating up to 24 patients sequentially per session.

In August 2002, an oncology clinic in Nebraska was investigated after 4 clinic patients developed HCV.

Ninety-nine clinic-acquired HCV infections were identified. HCV genotype testing of 95 specimens showed that they were type 3a, which is rare in the US. A person with chronic HCV infection, also type 3a, who began attending the clinic in March 2002, was also identified. It was found that a health care worker used the same syringe to draw blood from central venous catheters and to draw catheter flushing solutions from 500 cc bags used for multiple patients.

Though the transmission of HBV and HCV in the health care setting is rare, it should be suspected when cases are detected among persons without traditional risk factors. These reports reinforce the importance of all health care facilities, including outpatient facilities to:

- **Provide adequate oversight of staff performing any invasive procedure.**
- **Reinforce infection control guidelines, especially aseptic technique and safe injection practices during regular staff in-service training.**
- **Establish written infection control policies and procedures.**

1. CDC. Transmission of hepatitis B and C viruses in outpatient setting--New York, Oklahoma, and Nebraska, 2000-2002. MMWR. 2003;52:901-6.

Disease Reporting

AIDS/HIV(206) 296-4645
STDs(206) 731-3954
TB(206) 731-4579
All Other Notifiable Communicable
Diseases (24 hours a day)..... (206) 296-4774
Automated reporting line
for conditions not immediately
notifiable(206) 296-4782

Hotlines

Communicable Disease.....(206) 296-4949
HIV/STD.....(206) 205-STDS

Online Resources

Public Health Home Page: www.metrokc.gov/health/
The EPI-LOG: www.metrokc.gov/health/providers
**Subscribe to the Public Health Communicable
Disease listserv (PHSKC INFO-X) at:**
<http://mailman.u.washington.edu/mailman/listinfo/phskc-info-x>

| Reported Cases of Selected Diseases, Seattle & King County 2003 | | | | |
|--|--------------------------------|------|-------------------------------------|-------|
| | Cases Reported in September | | Cases Reported Through September | |
| | 2003 | 2002 | 2003 | 2002 |
| Campylobacteriosis | 30 | 26 | 196 | 236 |
| Cryptosporidiosis | 2 | 4 | 32 | 16 |
| Chlamydial infections | 444 | 342 | 3,758 | 3,179 |
| Enterohemorrhagic E. coli (non-O157) | 0 | 0 | 1 | 0 |
| E. coli O157: H7 | 14 | 3 | 32 | 19 |
| Giardiasis | 15 | 12 | 90 | 137 |
| Gonorrhea | 110 | 133 | 1,026 | 1,070 |
| Haemophilus influenzae (cases <6 years of age) | 0 | 0 | 0 | 0 |
| Hepatitis A | 3 | 32 | 21 | 28 |
| Hepatitis B (acute) | 7 | 5 | 29 | 25 |
| Hepatitis B (chronic) | 31 | 73 | 415 | 414 |
| Hepatitis C (acute) | 1 | 0 | 8 | 9 |
| Hepatitis C (chronic, confirmed/probable) | 44 | 87 | 689 | 1183 |
| Hepatitis C (chronic, possible) | 16 | 22 | 176 | 314 |
| Herpes, genital (primary) | 44 | 57 | 470 | 500 |
| HIV and AIDS (includes only AIDS cases not previously reported as HIV) | 60 | 34 | 354 | 453 |
| Measles | 0 | 0 | 0 | 0 |
| Meningococcal Disease | 0 | 0 | 3 | 15 |
| Mumps | 0 | 0 | 0 | 0 |
| Pertussis | 41 | 11 | 209 | 92 |
| Rubella | 0 | 0 | 0 | 2 |
| Rubella, congenital | 0 | 0 | 0 | 0 |
| Salmonellosis | 27 | 19 | 180 | 160 |
| Shigellosis | 5 | 10 | 79 | 50 |
| Syphilis | 7 | 2 | 64 | 31 |
| Syphilis, congenital | 0 | 0 | 0 | 0 |
| Syphilis, late | 5 | 4 | 35 | 28 |
| Tuberculosis | 9 | 16 | 116 | 113 |

The *Epi-Log* is available in alternate formats upon request.